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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**Roy Quinones, M.D.**<br>**660 4th Street, Ste. 150**<br>**San Francisco, CA 94107-1618**<br><br>**Physician's and Surgeon's Certificate No. A 81287,**<br><br>Respondent. | Case No. 800-2017-030764<br><br>**A C C U S A T I O N** |

Complainant alleges:

## PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On December 4, 2002, the Medical Board issued Physician's and Surgeon's Certificate Number A 81287 to Roy Quinones, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2018, unless renewed.

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

.....

"(c) Repeated negligent acts. . . . .

". . . ."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

## FACTS

7. At all times relevant to this matter, Respondent was licensed and practicing medicine in California.

## PATIENT P-1[1]

8. Respondent treated Patient P-1 from approximately July of 2011 until his death on June 24, 2013, at the age of 48. He had been diagnosed with, among other things, chronic low

[1] The patient is designated in this document as Patient P-1 to protect his and his family's privacy. Respondent knows the name of the patient and can confirm his identity through discovery.

back pain, a laminectomy, bilateral foot drop due to compressive neuropathy, hepatitis C, extrinsic asthma, and alcohol abuse, episodic before seeing Respondent.

9. In the eight visits for which there are medical records, there is documentation of only one relatively complete examination of P-1's back, on February 27, 2013. Typically, Respondent's assessment of P-1's back was simply, "No CVA tenderness."

10. Between August 2011 and June 2013, Respondent prescribed escalating amounts of both hydrocodone with acetaminophen[2] and oxycodone[3] to treat P-1's chronic pain. The chart notes for P-1 do not reflect that Respondent described the risks and benefits of opioid medications, including, despite P-1's history of alcohol abuse, the risk of drinking alcohol while taking opioid medications, or that he obtained informed consent for the opioid treatment from P-1. The morphine milligram equivalency[4] (MME) of the opioids Respondent prescribed for P-1 increased over the time he treated him from an average of approximately 106 MME daily the last half of 2011 to 223 MME the first half of 2012, 250 MME the second half of 2012, and 267 the first half of 2013. Despite these escalating doses of opioids and P-1's significant liver disease—as reflected by his diagnosis of hepatitis C and elevated liver enzymes—Respondent did not refer P-1 for alternative pain treatments or to a pain specialist.

11. On January 8, 2013, Respondent's chart notes for P-1 added an assessment of depression with anxiety. Respondent prescribed 1 mg clonazepam[5] tablets for P-1 to be taken twice a day. The chart notes do not reflect that Respondent described to P-1 the various risks of

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[2] Hydrocodone bitartrate w/APAP (hydrocodone with acetaminophen) is also known by the trade names Norco and Vicodin, among others. Hydrocodone bitartrate is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and, since October 2014, a Schedule II controlled substance. Before that, it was classified as a Schedule III controlled substance. Hydrocodone bitartrate is a nervous system depressant.

[3] Oxycodone IR (a trade name for immediate release oxycodone hydrochloride) is a short-acting opioid analgesic. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic. It is a more potent pain reliever than morphine or hydrocodone.

[4] Morphine milligram equivalency (MME) is a method used to convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine so 60 mg of oxycodone is equivalent to 90 MME. Hydrocodone is equally potent as morphine so 60 mg of hydrocodone equals 60 MME.

[5] Clonazepam (trade name Klonopin) is an anticonvulsant of the benzodiazepine class of drugs. It is a long-acting benzodiazepine. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs.

taking a benzodiazepine medication, including the risk of combining it with other respiratory depressants such as opioid medications or alcohol, or that he obtained informed consent for the treatment from P-1. On January 16, 2013, Respondent increased P-1's clonazepam dosage to 2 mg tablets to be taken three times a day.

12. Although Respondent assessed P-1 with depression with anxiety on each successive visit, he did not prescribe an anti-depressant for P-1, did not document having considered or discussed the possibility of prescribing an anti-depressant for him, and did not document having referred him to a psychiatrist. Respondent continued prescribing clonazepam for the condition.

## CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts and/or Failure to Maintain Adequate Records)**

13. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivision (c) (repeated negligent acts), and/or 2266 (inadequate records) of the Code in that Respondent has engaged in the acts described above, including, but not limited to, the following:

A. Respondent failed to document having advised P-1 of the potential risks of using a benzodiazepine while also taking other respiratory depressants such as opioid medications or alcohol, particularly in light of the escalating doses of opioids he was taking.

B. Respondent failed to document having warned P-1 about the dangers of drinking alcohol while taking the respiratory depressants oxycodone, hydrocodone, and clonazepam and with a diagnosis of hepatitis C and elevated liver enzymes.

C. Respondent failed to document having referred P-1 to a pain specialist or for alternative treatment despite prescribing escalating amounts of opioid medications for him and despite his significant liver disease.

D. Respondent failed to prescribe or document having considered prescribing anti-depressant medications to P-1 for his depression or to refer him to a psychiatrist for assessment and/or treatment of his depression.

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## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Respondent's Physician's and Surgeon's Certificate Number A 81287;

2. Revoking, suspending or denying approval of Respondent's authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: November 28, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*